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# Recovery Advocacy in England: An Interview with Oliver Mates

William White
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A vibrant recovery advocacy movement is rising in the UK that is expanding pathways to long-term recovery and transforming the core ideas, service practices and service policies that shape addiction treatment in the UK. When I began asking people who could best provide a view of this recovery movement "on the ground," many people suggested that I interview Ollie Mates. After interviewing him, I understood why his name had been suggested by so many. With a wonderful mix of candor, humility and great passion, Ollie describes in the interview below how his own personal recovery journey led to his role in this much larger movement. Please join me in this engaging discussion.

**Bill White:** Ollie, your involvement in recovery-related concerns began in Dublin, Ireland at the height of the Irish heroin epidemic. Could you describe this period?

**Ollie Mates:** I was sixteen years old and lived within three miles of Dublin city centre, on the north side. It was an area with very high unemployment and poor housing. I was already drinking alcohol and had been for two years. I smoked pot but only occasionally, and was involved in crime, mainly commercial burglaries. At 16 years I injected heroin with two friends who had already used. As soon as I became involved I realised there was a whole new world waiting for me. I quickly discovered that almost everyone I knew was using heroin. I didn't know anyone that smoked – everyone was injecting, and soon I was injecting every day. There were no syringe exchanges, so the large bins at the back of the hospitals were always a good bet to find usable works, and everyone was sharing. Syringes were a commodity; you could buy and sell them. Between 16 and 18, I had four hospital admissions with hepatitis. I was prescribed 30mg methadone, and I was using between a half and a gram of heroin daily, and continued to do so. I entered my first alcohol rehabilitation centre, the Rutland Centre in Dublin,

and I left on day one. Everyone in there was older than me and I just thought I was too young. I can only describe this period as chaotic. But it was around this time that I was first introduced to both AA and NA.

Dublin in the 1980s was like a war zone. Often you'd see three, four or five members of the same family getting hooked and a lot of the parents got together – Parents Against Drugs, and they began street marches to dealers' houses. They'd bust open the doors and throw their furniture out the windows. Sinn Féin were involved, shootings were pretty regular, kneecaps and killings. It was mainly controlled by one family, don't forget Dublin's a fairly small city by American standards. And it was viral – this talk about contagious addiction, well Dublin is a prime example. It spread through neighbourhoods literally overnight. It took a long time for the government to acknowledge there was a problem. It wasn't until government ministers' kids were getting involved, and middle class areas were being affected that any action was taken. The drug service was based in Dublin city centre, Jervis Street Hospital. It was daily dispensing on the premises including Sunday, and you'd wait months for the privilege. If you missed a day you were off the books. You got a script on the basis that you'd go into rehab. I ended up going to Coolmine. I stayed there for over two years. I got caught doing an armed robbery of a garage and got a five year sentence. The sentence was suspended on the condition that I stay in Coolmine for two years.

**Bill:** Did your professional work in addiction treatment begin in England? How did that occur?

**Ollie:** After I graduated from Coolmine I became a volunteer there. I was 21 or 22. They used to give you twenty cigarettes and a bus pass. Coolmine would take people from Malta and I got quite close to this guy who was an ex-drug squad officer in Malta and he was quite keen to see how drug treatment could work. The idea was that he would go back to Malta and mirror the programme there. Malta and Ireland had close links, very strong Catholic communities. This guy lived like a resident but a lot of the residents didn't like him because he was drug squad. When he left, he wrote and asked Coolmine if I could go over there, and the courts agreed as long as I was still under the banner of the treatment centre, and had a clear bill of health which meant I had to get rid of the hepatitis which I had. I went over there and I worked on the programme and stayed drug and alcohol free.

I returned to Dublin after 18 months, and I celebrated with a drink. I had to leave Ireland pretty quickly, I'd upset too many people, but I had references from Malta, from Dublin and I went to London and I got a job in a car wash – I had some knowledge of mechanics. I used to buy the Guardian, which had all the social care jobs, and I'd wait till the boss went on his lunch and I made all these phone calls. I got a job in Phoenix House in London. Reagan and Thatcher had declared war on drugs, just say no, and Phoenix became involved and organised demonstration marches. I voted myself in as a leader for London but it's a big place and I didn't know it too well so they sent me to Wirral to lead the campaign up here. I was in my mid twenties and I was drinking every day, working in services, so-called recovery services. Talk about the sick working with the sick. Anyway, I applied for a job in Merseyside Drugs Council and I got it. That's when I started working in methadone treatment. I liked Merseyside, it's small, friendly, with a big Irish community. I got involved with a local GP who was the main prescriber, really I taught him everything he knows. Today he's the clinical director for Wirral and nationally renowned and we're still good friends. In fact we're celebrating the twentieth anniversary of Wirral Drug Service today!

**Bill:** How and when did you become involved in the UK Recovery Movement?

**Ollie:** I'd worked in the drug service for ten years really, as a keyworker managing a caseload of methadone prescribed clients. I was seeing the clients on a monthly to three-monthly basis, mostly in the community in GP surgeries. It was mostly script and go with very little going on in the way of interventions. I was using quite a lot of cocaine and I was drinking a lot, and it was becoming evident, I was in trouble. So I put in a transfer request to move to another location outside the borough but working for the same organization. I had a very chaotic episode that resulted in a mental breakdown. One of the members of staff I was managing at the time brought in an AA Big Book, and suggested that I read it and consider going to a meeting. I ended up going to both AA and CA. I hadn't been to a meeting for quite a number of years; it must have been ten years. But this time it was different. I was broken. I'd lost a house, I'd lost a wife. I don't know how I managed to work. But I confided in my manager. She got me a doctor's appointment and she offered to come with me. I took three months off and I hammered the meetings, two or three a day. This was about 2003.

Things began to change very quickly. My life changed, and when I did the step three prayer the heavens opened. I carried on with the meetings, I went back to work, and I decided I wanted to return to the Wirral, but I couldn't go back to the same way of working, that script and go. It was soul destroying, and there was no enjoyment. I wanted to make a difference. I'd seen that the fellowships, and the value of mutual aid and spirituality could make a real difference to people's lives. I wanted a door to open that would allow me to make a real difference to people's lives. And the opportunity to manage the Community Detox Team came up. That was a small team. They were good people, and they knew lots about treatment and were willing to go the extra mile. But in terms of recovery there was a real gap, it was like trying to make a cake without flour and eggs. They had no concept of mutual aid, of addiction as a chronic condition. With the best will in the world they were sticking plasters on a gaping wound.

Then in 2007, a few of us came together, and realised we needed a Big Idea. There was Gary Rickwood, the local commissioner, Jane Newcombe, who managed the Treatment service, Mark Gilman, who was the regional manager of the National Treatment Agency, and his deputy Mark Harris. No-one used the terms ROIS or ROSC, but in effect that's what we were planning. The system needed to change and none more so than the main methadone treatment provider. We needed to be our own worst critic.

I started to look at what was happening in the States, in Philadelphia, Connecticut, reading lots of your own writings – Slaying the Dragon, Pathways, all the system transformation stuff – and I realised we needed to look at our own practices. And it hurt. People were being challenged around their work. The strategy was good, but the culture was in dire need of transformation.

In 2008, Stuart Honor and Justine Karpusheff carried out a piece of research, *Homage to Methadonia*. They found there was nothing to support and sustain recovery in Wirral. We realised we needed to build a system, an integrated system geared towards recovery. We needed to break down barriers between treatment and recovery services, and even between different recovery philosophies that were often in competition. We realised we needed to cooperate and collaborate, not to compete.

Meanwhile, in Liverpool, which is just across the Mersey from Wirral, recovery was mushrooming. Largely I think because of two twelve-step

providers that were feeding people into the fellowships. And most of the people from Wirral were traveling over there for their recovery. In fact Merseyside – Liverpool and its surrounding areas – was Recovery Central in the UK. And recovery had a vocal and articulate advocate in Mark Gilman, who led the drug treatment agenda in the North West of England. Throughout all of this, I was attending conferences and giving workshops, I was getting to know recovery advocates and treatment and service providers from all over the country. Meanwhile, Wirral's reputation as leaders within the recovery movement grew very quickly, largely because of system design, and the fact that the National Health Service was really playing a part in recovery. This was extraordinary for a treatment centre that had operated under a medical model for so long. So we were centre stage, and people were coming to visit us from across the country to replicate the service model, both the ROIS and the recovery-oriented medical treatment provision. And we took that vision to other regions, other areas, through the Recovery conferences that began to replace treatment seminars.

**Bill:** From your vantage point, what have been the most important milestones within this movement?

**Ollie:** Well Bill, recovery has always been out there, but certainly not as visible as it is today. And of course it's going to get bigger and more visible by far in the years to come. We are at the beginning of a journey. But some events stand out. About the same time as the National Treatment Agency was talking about Treatment Effectiveness Strategy, Mark Gilman initiated a North West Recovery Pilot, aimed at encouraging commissioners to design systems along the model of a ROIS. The goal was very much to integrate recovery into the treatment journey, and the Effectivenss Strategy was looking at treatment as a journey with a destination.

The Recovery Marches, first in Liverpool, then Glasgow, put recovery on the streets, with a lot of faces and some very loud voices. Jacquie Johnston Lynch was instrumental in getting that going and she was also the energy behind the Candlelit Vigils, now an annual event in Liverpool that brings people in recovery together in a very public, powerful and moving way.

The foundation of the UK Recovery Federation represented the beginnings of some coherent structure of the movement as a whole. In fact, they are the strategists uniting a very powerful army of recovery activists across the UK,

bringing people with real, sustained, authentic and rooted recovery to the forefront of the movement, people who would otherwise remain invisible.

And Wired In, with David Clark and Michaela Jones, the internet-based recovery community blog has given a platform to people in recovery and is a source of great hope and inspiration to many who aspire to a better way of life.

Also, I think the introduction of the Treatment Outcome Profile, and the data that provided shifted the focus from retention to outcomes. And the shift in commissioning requirements from treatment to recovery focused systems.

And of course, the 2010 Drug Strategy, that put recovery at the heart of all treatment interventions for alcohol and other drug problems, and the subsequent shift in strategic thinking towards nurturing the building of recovery in communities.

**Bill:** After a long tenure working at Wirral Drug Service, you took on the challenge of reshaping treatment services towards a more recovery-oriented model. Could you describe these efforts?

**Ollie:** In 2007, when we began to start building a more recovery focused system. I conducted a service user audit to look at what our service users *wanted*, how long they had been in treatment and what their plans were. I asked questions along the lines of: when you first came into treatment did you think you would still be here at this time in your life? I also reviewed all the inpatient detoxification spreadsheets, looking out for those that were serial repeaters attempting to become drug free but somehow clearly appearing year after year on the same spread sheet. This told me that we had lots of people who clearly wanted to leave the treatment service, but were somehow stuck. I looked at all the service guidelines, strategies and policies. It was crystal clear we had them all, but without the *culture* they were not worth the paper they were printed on.

Again I was researching the States and was becoming more and more obsessed with what was going on there. Faces and Voices of Recovery in the states were becoming big in my mind and I just knew that this was crucial to the UK we needed to replicate it. I knew deep in my heart that with the right people and a feel for the States I could help bring it about. The big question was, we needed to effect a change in the culture, a power transfer away from

us (the professional who knows best) to you (the *real* expert with the lived experience). Everyone has something to offer. I began thinking about volunteers and how I could go about bringing them in. Could I convince the NHS of the value of our former service users offering their experience strength and hope to those still within the system?

So, the biggest change we needed to achieve was around the culture within the service: getting people seen on a more regular basis; seeing relapse as part of some people's journey, rather then using it as a stick to criticize people with; challenging the stigma around people returning to the treatment system; and not viewing re-admission as a failure or non-compliance. This was a big challenge because we were forced to look at flaws in the system rather than blame the client – after all, why would people not want to attend if the system was attractive and the recipients felt cared for? We had to get the staff to acknowledge that everyone mattered and recovery was possible at any given time. We had to stop writing people off and looking at recovery being about quality of life and treatment being a big part of it. We had to get people thinking beyond the point of discharges and out of treatment being this brief intervention followed by a termination of the service relationship .The big challenge is also not allowing the professional expert to dominate the assessment and treatment process and allowing the service user to have and take ownership of their own journey.

Together with two colleagues, Damien Prescott and Vincent Hessey, we came up with some Top Tips for the NHS to embrace recovery (see attachment at end of interview), and we've been using it ever since to try and bring about a paradigm shift in the culture and practices of the treatment service.

**Bill:** What has been most difficult about that process?

**Ollie:** This was definitely in getting everyone to acknowledge that we the professionals do not have all the answers and it is more important to live with the right question than to have the right answer. The foundation of the old system has been one of a medical regime. We have created a model where we focus far too much on the capabilities of specialist workers and doctors to turn people round, when that is way beyond their capacity, rather than acting as a bridge to building recovery communities.

Many people working within the field are threatened by the whole recovery movement. I have been on many occasions personally attacked for my outspoken views by the very staff I work with in trying to bring about the change. Treatment in this country is a massive industry and people are making a great deal of money out of it. Recovery is a reality, but that's not the view of all our service providers. I still think that although we have made great progress, some of our service staff still have little or no interest in self help or mutual aid, in recovery in general. They are happy to develop their knowledge around treatment, and are always interested in seeing the medical rep selling their products. But when it comes to recovery events and meetings they are invisible. I think there is also not enough evidence in recovery research to prove the skeptics wrong and there is little or no existing research from commissioners or policy makers in this area and in this country.

It was hard also getting the system to acknowledge that recovery is integral to treatment, and we could no longer say that we were a treatment centre and leave recovery to another service or tag it on the end of what we were doing. I guess it was saying we all have a part to play here and we are part of this journey as well, putting the person at the center of everything we do. The big problem was how we help bring about that culture from a script-and-go service to a person-centered service—to a system that looks at strengths rather then always focusing on the problem. I am sad to say our assessments are still problem focused. Trying to get the staff to acknowledge that recovery was possible at any given time has also been a challenge.

I began to become involved in a recovery group that was just beginning to start out in Occupational Health that was looking at recovery in mental health and I managed to get onto that group.  My initial thoughts was that here I had an opportunity to send a clear message right across the Trust to adopt a culture around service users that would involve them in there treatment every step of the way. That meant we set out a strategy that says "Nothing about us without us" I liked that and we all agreed that we would adopt that into the strategy again many of the staff were uncomfortable with it and still are and that again can be very difficult. The most painful bit about recovery is that resistance to change. The very people that are supposed to be facilitating that change are so resistant to it themselves.

**Bill:** What are the most important successes you have had in this effort?

**Ollie:** Well Bill I must say that recovery is well embedded in this treatment system and it's here to stay. There's nowhere to hide. The success I think would be that I have managed to get the service to take the lead on three Conventions, Recovery events that would put a Face and Voice on Recovery. This has now become a marked calendar event and over the last three years has grown. In 2009 we had the Recovery walk in Liverpool another event where recovery was able to be seen and heard. I have also been able to form Service User Recovery Forums where we all meet and discuss services and feed back to Commissioners. As of this week we've formed a Merseyside recovery network that is bringing people together, especially the invisible army of people in long-term recovery, coming out to support the movement and be more visible. Most importantly, the service I work for is taking recovery seriously and those we serve are being seen more frequently and recovery has become the default position so people are being invited to explore it on treatment initiation.

Another major success is the recruitment of service user volunteers, who are visible within the treatment service and have the lived experience that they can share with the staff and service users. Ironically Bill these are some of the very people that we all said many years ago that they just aren't going to make it. We expected them to be in service until they died. They are now the people in the front line meeting and greeting people accessing the service. Their criminal records are being seen as their qualifications and assets. This was and is a major shift for the NHS. Recovery Volunteers are now playing a big role in reshaping the service helping to match he service user to the treatment that best suits them, talking to clients openly and honestly about what their treatment objectives may be, including ones that they may not have previously considered. One of the main roles for the recovery sponsors is that they are visible icons of recovery. Another is communication, and this has brought about some major systemic changes.

**Bill:** What models have you drawn upon to guide this work?

**Ollie**: Most definitely my experience in Philadelphia and Connecticut changed my whole world around recovery and treatment. It has had a major influence on my thinking, it challenged my beliefs and it gave me an injection of hope and faith, and the courage to come back here and begin to reshape my course. The biggest impact was the Volunteers and how that can

influence change and bring about recovery in a very simple way. Connecticut taught me about telephone-based recovery and how that influenced people's journey. Also striking was the dynamics amongst the staff team, volunteers and service users, with all viewed as equals, each having assets and drawing upon each others' skills and experience. That therapeutic alliance came across very strong.

I think another learning curve was getting those in power within this service acknowledge we were too high on protocols and low on quality. The impact of the whole USA experience has transformed my way of delivering treatment services and has most definitely transformed the service I work in here. I realised the one thing that services cannot deliver was the love that people need when they are sick. Your own writings have been particularly inspirational, Bill, the vision of transformation that permeates communities beyond drugs and alcohol. Also the work of John McKnight, and the paradigm shift from a deficit to an asset-based approach.

**Bill:** Do you see all treatment services in the UK moving toward greater recovery orientation?

**Ollie:** I think the time has come and we are already experiencing a massive transformation in this country as all services continue to become more genuinely recovery-focused using a more person centered recovery approach. At the moment, some services think that you can be recovery-focused simply by adding the word "recovery" to the service name. But the shift is happening, there's just something in the air. The movement is now too large, the foundations have been built and they've been built on assets, on strengths and on values. They're solid and they're unshakable. The idea that the user is a problem and needs to go on an endless treatment journey is now outdated, and the many of the communities that were epicenters of addiction are becoming communities of recovery. There voices can no longer be ignored. Government policy has embedded recovery in treatment delivery, and the focus is on outcomes rather than outputs.

**Bill:** Do you see a future in which peer-based recovery support will be a standard component of all addiction treatment in the UK?

**Ollie:** Bill, for this area which had mainly a large proportion of Methadone dependent people we have for some time been using peer based recovery in creating a genuine recovery focused system. The concept of recovery

remains a challenging question for many, but the fact that we are now able to put a face to it is what is bringing about that change means that no-one can ignore the fellowships or the other peer-led recovery networks. The fellowships have grown exponentially in Wirral, from only one meeting a week to one a day in a very short time period. The picture in Liverpool is even more dramatic.

**Bill:** One of your areas of deep interest is the potential role of spirituality in addiction treatment and recovery. Could you discuss how you see this role?

**Ollie:** Many people see spirituality being tied to religion. However, although a churchgoer I don't see myself as religious. I have my convictions. I love the old saying, that many things will catch your eye, but pursue only those that capture your heart. I find that peace and happiness are available at every moment as long as I'm doing the right thing. I find that this work fills my soul and meets my needs. That's spirituality. It's the foundation of wellbeing, and if you don't have that deep-rooted sense in your own soul, you have emotional turbulence and that's a big risk to recovery. Many of us suffer with broken souls, broken hearts, and our spirits need healing. But it's a deeply personal journey. In this country, people do tend to shy away from that, but it's integral to the recovery process, and we shouldn't be frightened of saying so. Addiction is a soul sickness and we need soul doctors every bit as much as we need medical practitioners.

**Bill:** One of the things people most often say about you is that you love your work and experience a contagious joy in your work with people in recovery. What is the source of that joy?

**Ollie:** Being around people in recovery is a source of joy. There's a whole new world out there. I'm seeing people who were alone, isolated, stigmatized, coming together and entering a world with meaning, with purpose with so much humour and fun. I'm seeing the passion blaze up in people who were in the pits of despair. It's essential to my own recovery journey, being involved in something much bigger than me and my own little life.

**Bill:** You have expressed great concern about the social and professional stigma addicted and recovering people experience in the UK. What strategies do you think would help lower that stigma in the future?

**Ollie:** The UKRF are front and centre here, the candlelit vigils, the recovery marches and the conventions. But most of all, the fact that the very people whose addictions tore communities apart are now rebuilding those communities. The evidence is in the fruits – that when people recover, they become major assets.

**Bill:** You have been involved in the worlds of addiction treatment and recovery for more than 25 years. What are some of the most important lessons you've learned that you could pass on to persons who are just entering these arenas as service recipients or service providers?

**Ollie:** To recipients, I would say: be open-minded, listen and learn, especially from those who've gone before you. Believe in yourself, recognize your strengths and be mindful of your values. To professionals I would say never, ever write anyone off. Focus on strengths and on assets. Be humble and learn. Recovery begins with understanding, and understanding requires an open mind. Drugs and alcohol are only a symptom – it's the broken hearts we need to focus on.

**Bill:** Ollie, thank you for your willingness to talk about your life's work and for all you have done on behalf of the recovery movement.

**Ollie:** Thanks Bill, for your own example. You're an inspiration to us all.

## Top tips for an NHS Recovery movement

1. There has to be relationship reconstruction between service users and practitioners. The unhealthy power dynamic that can sometimes exist between clients, keyworkers, doctors and nurses must be challenged.

2. Professionals need to become students of recovery, and allow it to be delivered from the bottom up. We need to be humble and open-minded, as our former service users become our teachers. Their previous experience and lifestyles, including criminality, are their qualifications – they must not be seen as barriers.

3. Recovery must be promoted at all levels of decision making.

4. Choice and empowerment are the key. We can guide, inform and educate, but we cannot tell people how they should recover.

5. If we are to be effective facilitators, we need to have at least some understanding of the various models. And we need to be impartial, presenting all options without prejudice.

6. Belief that recovery is possible at any stage. If we don't believe this, we need to go out there, listen to the stories, and see the evidence. Seeing is believing.

7. Don't write anyone off. Ever. Our belief in a client's ability to recover can influence positive outcomes. The opposite is also true.

8. We need to talk to recovery services, become familiar with the language of recovery, and allow that language to permeate and influence our own 'treatment' discourse.

9. Especially, we need to become familiar with the many self-help and fellowship groups. Every NHS substance misuse professional should be required to attend mutual aid meetings. This needs to be a non-negotiable part of their professional development and essential learning.

10. We should avail ourselves of the extensive resources at our disposal, harnessing the expertise of a highly skilled, multi-disciplinary workforce in the service of recovery.

11. Clients who relapse and return should be welcomed back and not shamed or stigmatised. A relapse is a setback – it is not a failure. However, peer support should be the first port of call, except where medical intervention is essential.

12. Recovery must be the bedrock of substance misuse treatment within the NHS, and the ultimate goal of all interventions. As we continue to witness the transformation of our service users, we must allow ourselves to be transformed by their example.